Authorization to Release Dental Records

I, _____, authorize
(Print patient, parent or guardian name)

Dr. _____
(Dr. or office name and address)

_____

to release a photocopy of my dental treatment record to the dental office of:

Davies General Dentistry
2117 Corporate Dr Suite 200
Waukesha WI 53189
P: 262.522.7878
Fax: 262.522-0570
E mail: info@daviesdentistry.com

Please email, fax or mail the requested materials.
(We have Dexis. If possible, please email the installable DEXview.)
Thank you!

Requested Materials:

X-rays
(Bitewing x-rays taken in the last 2 years and Panorex/Full mouth x-ray taken in the last 5 years),

Periodontal Charting

Patient's Name_____

Date of Birth_____

Signature_____Date_____
(Parent or legal guardian must sign if patient is a minor)

PATIENT IS RESPONSIBLE FOR SENDING THIS AUTHORIZATION FORM TO THEIR PREVIOUS DENTIST FOR RELEASE OF DENTAL RECORDS. THANK YOU!